Supplement B: EPSDT

Last Updated: 03/14/2022

Table of Contents

Supplement B: EPSDT

Qualified EPSDT Screening Providers

Qualified providers of EPSDT screening services include:

- A physician licensed by the Board of Medicine;
- A physician assistant licensed by the Board of Medicine under supervision as required by their license;
- A nurse practitioner licensed by the Board of Nursing under supervision by a licensed physician;
- Federally Qualified Health Centers (FQHCs);
- Rural Health Clinics (RHCs);
- Local health departments;
- School based health clinics; and
- Other DMAS approved clinics

EPSDT providers must be Medicaid enrolled providers and must meet all applicable Medicaid provider and specific EPSDT screening requirements. There are no additional enrollment requirements for qualified providers to participate in EPSDT.

The Primary Care Physician's Role in Screening

PCPs for children in MCO's must directly provide EPSDT services for all children assigned to them. Those children who are not enrolled in managed care may obtain these services from any Medicaid enrolled physician or clinic qualified to provide EPSDT services and also offers these services. These qualified Medicaid enrolled fee-for-service EPSDT providers must follow the same requirements indicated in this manual. The Managed Care Help Line maintains a list of these providers. There are no special enrollment procedures for recipients to access EPSDT services.

The PCP or EPSDT screening provider (both MCO and FFS), must perform the following activities related to screening services:

- Advise families of the importance of regular preventive health care for their children and explain EPSDT services.
- Provide or arrange for initial and periodic EPSDT preventive health screenings according to the DMAS periodicity schedule and screening requirements.
- Assure that the initial screening is scheduled within thirty (30) days of notification of managed care assignment and immediately upon notification of newly assigned newborns unless the services are declined.
- Notify families when the next screening is due including those families who have previously declined screening services and encourage them to keep all screening appointments.
- Schedule the next screening appointment and maintain periodicity and tracking system on screenings.
- Follow up on missed or incomplete screenings including contacting families and rescheduling the screenings promptly.

- Coordinate care for children referred to other qualified providers for screening services and specialty care and obtain results of the screenings and other health care services.
- Maintain a comprehensive and integrated medical record of all health care the child receives including complete documentation of all EPSDT screening components and immunizations given.

MCOs may assume responsibility for some of the informing, tracking and notifying functions of PCPs. One of the primary goals of DMAS' managed care programs is to promote a "medical home" for children so that recipients under the age of 21 receive both sick and well care from their PCP rather than seek episodic care from an emergency room. A PCP who chooses not to directly provide screening services must enter into a formal written agreement with a local health department, FQHC, or other qualified EPSDT provider to provide screening services to children in his panel. The referral duration will be at the discretion of the provider, and must be fully documented in the patient's medical record. "Exhibits" at the end of this chapter contains an optional referral form for this purpose. Regardless of the screening arrangements, the PCP must continue to be responsible for the informing, tracking, follow-up and documentation requirements of EPSDT.

The EPSDT Screening Periodicity Schedule

EPSDT screenings are Medicaid's well child visits and should occur according to the "American Academy of Pediatrics Recommendations for Preventive Pediatric Health Care". The DMAS periodicity schedule is included as Appendix 1 under "Exhibits" at the end of this chapter. Providers must obtain a medical history that is inclusive of mental health risk factors and documents the family's history of mental health conditions.

EPSDT screenings, inter-periodic screenings and the required components of the screenings do not require service authorization requirements. However, screenings not performed by the child's PCP require a referral from the PCP. Children not enrolled in managed care are not subject to this referral requirement.

EPSDT Screening Components

This Section describes the required components of EPSDT screenings for members enrolled in Fee for Service and Managed Care Organizations. The EPSDT comprehensive health screening/well child visit content should be in line with the most current recommendations of the **"American Academy of Pediatrics (AAP), Guidelines for Health Supervision"**. Another resource for preventive health guidelines is the AAP compatible **"Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents"**. All components of EPSDT screenings, including specimen collection, must be provided during the same screening visit.

The following is a description of each of the required age appropriate screening components:

Comprehensive Health and Developmental/Behavioral History

At the initial screening, the screening provider must obtain a comprehensive health, developmental/behavioral, mental health and nutritional history from the child's parents or a responsible adult familiar with the child, or directly from an adolescent, when appropriate. This history should be gathered through an interview or questionnaire. A comprehensive initial history

includes a review of the:

- Family medical history (health of parents and current family members, identification of family members with chronic, communicable or hereditary diseases);
- Patient medical history (prenatal problems, neonatal problems, developmental milestones, serious illnesses, surgeries, hospitalizations, allergies and current health problems and medications);
- Nutritional history;
- Immunization history;
- Environmental risk (living conditions, water supply, lead, sewage, pets, smokers in home);
- Family background of emotional problems, problems with drinking or drugs or history of violence or abuse; and
- Patient History of behavioral and/or emotional problems (educational environment and performance, family and social relationships, hobbies, sports).

In addition, for all adolescent children, the initial history must include:

- History of sexual activity, if appropriate
- Menstrual history for females
- Obstetrical history, if appropriate

The history must be updated at each subsequent screening visit to allow serial evaluation.
Developmental Surveillance, Assessment, and Screening

DEVELOPMENTAL SURVEILLANCE

Developmental surveillance should be conducted at each well-child visit. Developmental surveillance is the process of recognizing children who may be at risk of developmental delays. Surveillance is longitudinal, continuous, and cumulative and is comprised of the following components: parental concerns; developmental history; observation of the child; identification of risk and protective factors; and accurately documenting the process and findings. The following are examples of conducting surveillance:

- Parental concerns: Simple questions to parents such as “do you have any concerns about your child’s development? Behavior? Learning? Asking about behavior can help identify issues, as parents may not be able to differentiate between development and behavior.
- Developmental history: Ask parents about changes since the last visit, and questions about age-specific developmental milestones such as walking, pointing, etc.
- Observation: The health care provider can often see evidence of age-specific developmental milestones, and may be able to confirm parental concerns. It is also important to monitor the parent’s response to the infant, and vice versa.
- Risk and protective factors: Infants born prematurely, at low or very low birth weight, or with prenatal exposure to alcohol, drugs, or other toxins are at risk for developmental delay. Protective factors to support infants at risk, such as participation in home visitation program, or strong connections within a loving and supportive family, should also be considered in determining the overall degree of risk.

Surveillance services are always a subjective observation by the practitioner. Reimbursement for well child visits includes surveillance activities because developmental, hearing and vision surveillance occurs during the course of each EPSDT visit. When a child has an issue that warrants further investigation by the practitioner, then the child may receive a screening to document the need for further assessment or evaluation.

DEVELOPMENTAL SCREENING TOOLS

If at any time developmental surveillance demonstrates a risk for developmental delay, a standardized screening tool should be administered to further assess the child. As recommended by the AAP, developmental screening using a standardized screening tool should occur at 9, 18, 24 and 30 months of age or at any time when surveillance indicates a risk for developmental delay. An autism specific screening is recommended at the 18 and 24 month visit. Children should be screened for developmental concerns at least 5 times while they are younger than three years of age.

Developmental assessment and screening differs from surveillance because the activity of assessment and screening includes the use of a standardized developmental screening tool. The tools used may vary according to the type of screening or assessment that is provided. All of the examples listed below can be performed by a parent or other office staff and interpreted by the physician during the "face to face" portion of the child's visit. These tools are designed to be used easily as part of the typical office work flow and the tools are very sensitive and specific with proven statistical validity.

Recommended Developmental Screening Tool

Parents' Evaluation of Developmental Status (PEDS),	Parent-report instrument used to identify general developmental delay in the general primary care population
Ages and Stages Questionnaire (ASQ),	Parent-report instrument used to identify general developmental delay in the general primary care population and/or broad highrisk population
Bayley Infant Neurodevelopmental Screen (BINS),	Practitioner-administered instrument used to identify general developmental delay in the high-risk population
Cognitive Adaptive Test/Clinical Linguistic Auditory Milestone Scale Expressive and Receptive Language Scale (CAT/CLAMS),	practitioner-administered instrument used to identify general developmental delay in the high-risk population
Language Development Survey (LDS),	parent-report instrument used to identify language delay in the general primary care population
Clinical Linguistic Auditory Milestone Scale Expressive and Receptive Language Scale (CLAMS),	practitioner-administered instrument used to identify language delay in the high-risk population
Modified Checklist for Autism in Toddlers (M-CHAT)	parent-administered instrument used to screen for autism and developmental delay in the general primary care population

Recommended Tools for Focused Screening for suspected health conditions:

Cognitive Adaptive Test/Clinical Linguistic Auditory Milestone Scale Expressive and Receptive Language Scale (CAT/CLAMS),	practitioner-administered instrument used to identify general developmental delay in the high-risk population
Language Development Survey (LDS),	a parent-report instrument used to identify language delay in the general primary care population
Clinical Linguistic Auditory Milestone Scale Expressive and Receptive Language Scale (CLAMS),	practitioner-administered instrument used to identify language delay in the high-risk population
Modified Checklist for Autism in Toddlers (M-CHAT)	parent-administered instrument used to screen for autism and developmental delay in the general primary care population

Hearing and Vision Screening and Surveillance

Subjective

The subjective screening for hearing and vision is part of the comprehensive history and physical examination. Children's hearing is assessed according to the AAP policy for "Hearing Assessment in Infants and Children: Recommendations Beyond Neonatal Screening". Children's vision assessment should be provided according to the AAP policy for "Eye Examination in Infants, Children, and Young Adults by Pediatricians". Hearing and Vision screenings follow the most current AAP periodicity schedule as stated in the AAP "Recommendations for Preventive Pediatric Health Care".

The Virginia Early Hearing Detection and Intervention (EHDI) program, the AAP, and the American Speech-Language-Hearing Association provide information on objective hearing screening methods for infants and toddlers.

The EHDI program has a resource, Protocols for Medical Management, that defines best practices for caring for infants and young children who are in need of follow-up from universal newborn hearing screening programs and for children who are found to have hearing loss. The Early Hearing Detection and Intervention protocols can be accessed the Virginia EHDI Program Web site, http://www.vahealth.org/hearing/. Early and consistent intervention specific to hearing loss is essential to achieving normal language development.

Information on vision assessment and surveillance may be found in The American Association for Pediatric Ophthalmology and Strabismus, the American Academy of Ophthalmology, and the American Academy of Pediatrics Section on Ophthalmology.

Screening and Testing Using Standardized Methods

The provision of hearing or vision testing using a standardized instrument during the well child visit is billable on that service day as a distinct service. Hearing and vision testing using a standardized instrument is eligible for reimbursement when performed according to the DMAS periodicity schedule or when required to monitor the progression of hearing or vision loss related to the presence of identified risk factors.

Virginia Law Regarding Hearing Screening at Birth

Virginia law requires that effective July 1, 2000, all infants will be given a hearing screening before discharge from the hospital after birth. Those children who did not pass the newborn hearing screening, those who were missed, and those who are at risk for potential hearing loss should be scheduled for evaluation by a licensed audiologist.

Comprehensive Unclothed Physical Examination

A complete unclothed physical examination must be performed at each screening visit. The examination must be conducted using observation, palpation, auscultation and other appropriate techniques using the criteria for specific age groups described in the latest edition of the *AAP Guidelines for Health Care Supervision*. The examination must include all body parts (or areas) and systems listed below:

- Cranium and face
- Hair and scalp
- Ears
- Eyes
- Nose
- Throat
- Mouth and teeth
- Neck
- Skin and lymph nodes
- Chest and back (using a stethoscope) to check for heart and lung disorders
- Abdomen
- Genitalia
- Musculoskeletal system
- Extremities
- Nervous system

The examination must include screening for congenital abnormalities and for responses to voices and other external auditory stimuli. Evaluation of the Tanner stage and scoliosis screening must be included as part of the complete physical examination at each screening visit beginning at age ten.

In addition, the height (or length) and weight of the child must be measured. When examining a child two (2) years of age and younger, the provider must measure the child's occipital-frontal circumference. All measurements must be plotted on age-appropriate, standardized growth grids and evaluated.

Evaluation of growth and laboratory measures is useful for assessing nutritional status. Assessing eating habits in relationship to developmental stage is also important. If dietary or nutritional problems are identified, a referral to the appropriate professional should be made.

For children three and above, the physical examination must include blood pressure measurement.

As part of the physical examination, excessive injuries or bruising that may indicate inadequate supervision or possible abuse must be noted in the child's medical record. If there is suspicion or

evidence that the child has been abused or neglected, State law requires medical professionals to promptly report it to the Department of Social Services' Hotline 1-800-552-7096 (Code of Virginia Section-63-248.3).

Immunizations and Laboratory Tests

Age appropriate immunizations should be provided according to the Advisory Committee on Immunization Practices (ACIP) guidelines. All "catch up" schedules for missed vaccines should follow ACIP guidelines. The child's immunization status must be reviewed from the child's medical record and interview with the parent at each screening visit. If the immunization history is based on the verbal report of the parents or other responsible adult, the information must be confirmed and properly documented, indicating the source.

Age-appropriate immunizations that are due must be administered during the screening visit. Immunizations given to a child during a screening visit may be billed separately. PCPs and other medical screening providers are required to participate in the Virginia Vaccines for Children (VFC) Program and provide necessary immunizations and information about the benefits and risks of immunizations as part of EPSDT screenings. The PCP and screening provider must ensure that every child is immunized according to the current Childhood Immunization Schedule approved by ACIP and AAP. A parent's refusal to allow immunizations must be documented by a statement in the child's medical record that is signed and dated by the parent. If a condition is identified during the screening that warrants deferral of necessary immunizations to a later date, the progress notes in the medical record must so indicate. The provider must follow up to reschedule the child to catch up on immunizations at the earliest possible opportunity.

VACCINES FOR CHILDREN PROGRAM

The Vaccines for Children (VFC) Program is a federal program established in 1984 to help raise childhood immunization rates in Virginia. VFC provides federally purchased vaccine, at no cost to health care providers, for administration to eligible children. Childhood immunizations and annual pneumococcal vaccinations are covered according to the most current Advisory Committee for Immunization Practices(ACIP) schedule.

To be eligible for free vaccine from the VFC Program, children must be under the age of 19.

VFC eligible must also meet one of the following criteria:

- Medicaid/FAMIS PLUS, enrolled, including Medicaid MCOs,
- Uninsured (no health insurance),
- Native American or Native Alaskans (no proof required) and
- Underinsured (those whose insurance does not cover immunizations).

Requirement to Enroll in VFC

To participate, a provider must complete the enrollment and provider profile forms provided by VDH. At this point, the provider is eligible to receive free vaccines under the VFC.

Upon enrollment, the Department of Medical Assistance Services will not reimburse the provider for

the acquisition cost for vaccines covered under VFC. Medicaid will reimburse providers the administration fee for routine childhood vaccines that are available under VFC (up to the age of 19). Medicaid will reimburse the provider an administration fee per injection.

Billing Codes for the Administration Fee

Providers must use Medicaid-specific billing codes when billing Medicaid for the administration fee for free vaccines under VFC. These codes identify the VFC vaccine provided and will assist VDH with its accountability plan which the Health Care Financing Administration (CMS) requires. The billing codes are provided in the Current Procedural Terminology (CPT-4) books.

Billing Medicaid as Primary Insurance

For immunizations, Medicaid should be billed first for the vaccine administration. This is regardless of any other coverage that the child may have, even if the other coverage would reimburse the vaccine administration costs. Medicaid will then seek reimbursement from other appropriate payers. When a child has other insurance, check “YES” in Block 11-D (Is there another health benefit plan?) on the CMS-1500 (08-05)claim form. See the Physician/Practitioner Manual for further instructions.

Reimbursement for Children Ages 19 and 20

Since Medicaid policy provides coverage for vaccines for children up to the age of 21, and VFC provides coverage only up to the age of 19, there may be instances where the provider will provide immunizations to children who are ages 19 and 20. Bill Medicaid with the appropriate CPT/HCPCS code and Medicaid will reimburse the acquisition cost for these vaccines. Medicaid will not reimburse an administration fee since these vaccines were not provided under the VFC Program to this age group.

Vaccines Not Available Under VFC

The Virginia Department of Health has no contracts with the Centers for Disease Control (CDC) for the VFC distributor to provide Diphtheria Tetanus and Pertussis (DTP) and Hepatitis B for dialysis patients. Therefore, Medicaid will reimburse for the acquisition cost for these vaccines under CPT codes 90701 and 90747, respectively. No administration fee will be reimbursed under code since this vaccine is not available under VFC.

Single Antigen Vaccines

Single antigen vaccines (such as measles, mumps, and rubella) are available from the VFC contractor but must be ordered by the provider with special justification since the combined antigen vaccine (MMR) is available. This is consistent with Medicaid policy to require medical justification for single antigen vaccines.

Pneumococcal and Influenza Vaccines for Adults Aged 19 and Older

Medicaid will provide reimbursement for these vaccines only if they are reasonable and necessary for the prevention of illness. Medical justification needs to be attached to the claim. The physician’s treatment plan on file in the patient’s medical record must indicate that the vaccine was provided to

prevent the occurrence of more serious illness in an individual "at risk."

Situations Where Vaccines Are Not Covered Under VFC

There may be some situations where a child is attempting to "catch-up" on vaccines that have been missed. In some cases, the VFC program will not provide coverage for these "catch-up" vaccines, and the provider will have to purchase them from his or her normal vaccine distributor. If this occurs, Medicaid will continue to reimburse the provider for the acquisition cost of these vaccines as long as there is information attached to the claim indicating the reason for billing Medicaid for the acquisition cost. In addition to the attachment to the claim, use modifier 22 in Block 24-D of the CMS-1500 (08-05) claim form.

Vaccines Provided Outside of the EPSDT Periodicity Schedule

Virginia Medicaid covers childhood immunizations under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program based upon a periodicity schedule. This schedule was developed by the Advisory Committee on Immunization Practices (ACIP) and the American Academy of Pediatrics along with representatives from the American Academy of Family Physicians. See Supplement B - EPSDT for a copy of the immunization schedule. If the provider provides a vaccine to a child that falls outside of this immunization schedule and the vaccine does not meet the criteria for coverage under the VFC Program, Medicaid will not reimburse for immunizations unless documentation is sent along with the claim to explain the circumstances under which the vaccine was provided. In addition to the attachment to the claim, use modifier 22 in Locator 24-D to bill Medicaid for the acquisition cost.

Billing for Childhood Immunizations

The Federal Vaccines for Children (VFC) Program provides routine childhood immunizations free of charge to Medicaid-eligible children up to age 19. These vaccines are provided to VFC enrolled providers by the Virginia Department of Health (VDH). DMAS requires that PCPs serving children and EPSDT screening providers participate in the VFC program. Providers may enroll in the VFC Program by contacting VDH at 1-800-568-1929. DMAS and the DMAS contracted MCO's will not reimburse providers for the acquisition cost of vaccines that are covered under the VFC Program. DMAS reimburses providers for the administration fee for routine childhood vaccines that are available under VFC (up to the age of 19). DMAS will reimburse the provider an $11.00 administration fee per injection. MCOs are responsible for provider payments of immunizations furnished to children enrolled in MCOs. Therefore, providers cannot be reimbursed by DMAS for immunizations provided to MCO enrolled children.

Reimbursement for Children Ages 19 and 20

Since EPSDT Federal regulations require states to provide coverage for vaccines for children up to the age of 21, and VFC provides coverage only up to the age of 19, there may be instances where the provider will provide immunizations to children who are ages 19 and 20. In these instances, the provider must use the appropriate CPT procedure code. DMAS will reimburse the acquisition cost for these vaccines. The charges in locator 24F of the HCFA 1500 (12-90) claim form must reflect the actual acquisition cost per dose. Providers should refer to Chapter V of the DMAS Physician Manual

for further billing guidance.

VFC Coverage of Other Vaccines

The VFC program covers other vaccines not included in the ACIP immunization schedule including single antigen vaccines. If the provider chooses to provide a single antigen vaccine, such as measles, mumps, or rubella, medical justification, which documents the medical necessity of providing a single antigen vaccine when the combined-antigen vaccine is available, must be attached to the claim. Claims for measles, mumps, or rubella vaccines will automatically pend for review by DMAS staff. The VFC Program also provides coverage for the pneumococcal and influenza vaccines for high-risk patients only. When ordering these vaccines through VFC, the provider must provide medical justification. DMAS will provide reimbursement for these vaccines only if they are reasonable and necessary for the prevention of illness. Medical justification does not need to be attached to the claim, but the physician's treatment plan on file in the patient's medical record must indicate that the vaccine was provided to prevent the occurrence of more serious illness in an individual "at risk".

Age appropriate immunizations are a federally required screening component. The provider must not submit a claim for a complete screening unless all required components that are due are administered and documented including appropriate immunizations according to age and history (unless medically contraindicated or the parents refuse at the time). Failure to comply with or properly document this screening requirement must constitute an incomplete screening and may result in denial of payments.

Laboratory Procedures

EPSDT REQUIREMENTS FOR LEAD TESTING

As part of the definition of EPSDT services, the Medical Statute requires coverage for children to include both screening and blood lead tests as appropriate, based on age and risk factors. The Centers for Medicare and Medicaid Services (CMS) requires all Medicaid enrolled children receive a blood lead test at 12 months and 24 months of age. In addition, any child between 24 and 72 months with no record of a previous blood lead screening test must receive one. The medical record will be deemed insufficient if the child has not been previously screened. Completion of a risk assessment questionnaire does not meet the Medicaid requirement. The Medicaid requirement is met only when the two blood lead screening tests identified above (or a catch-up blood lead screening test) are conducted (https://www.medicaid.gov/federal-policy-guidance/downloads/cib113016.pdf).

Confirmation of blood lead levels

Blood Lead level testing shall be performed on venipuncture or capillary blood; however, additional testing may be required, as described below. Filter paper methods are also acceptable and can be performed at the provider's office. The use of handheld testing machines must be approved through the Lead-Safe Virginia Program to assure proper quality assurance and reporting of data.

Tests of venous blood performed by a laboratory certified by the federal Centers for Medicare & Medicaid Services in accordance with 42 USC § 263a, the Clinical Laboratory Improvement Amendment of 1988 (CLIA-certified), are considered confirmatory. Tests of venous blood performed

by any other laboratory and tests of capillary blood shall be confirmed by a repeat blood test, preferably venous, performed by a CLIA-certified laboratory. Such confirmatory testing shall be performed in accordance with the following schedule (requirements of 12VAC5- 90-215):

If result of screening test (µg/dL) is:	Perform diagnostic test on venous blood within:
5-9	1-3 months
10-44	1 week - 1 month
45-59	48 hours
60-69	24 hours
70 or higher	Immediately as an emergency lab test

For consultation and assistance on the treatment of children with elevated venous blood levels 70 or higher contact Emergency Lead Healthcare through their free medical hotline at 1-866-767- 5323 (1-866-SOS-LEAD).

LEAD TESTING PROCEDURE CODES

If blood lead screening tests are conducted in the providers' offices, the code 83655 for Lead blood testing is used with one of the following: 36416 or 36415, depending on whether the sample is from a capillary or venous site, as shown below.

Service Description	Procedure Code
Lead Lab Test (paid to Lab or EPSDT screener)	CPT 83655
Capillary Sample (finger, heel, ear, stick)	CPT 36416
Venous Sample (recommended)	CPT 36415

When blood lead testing is provided to a client enrolled in a Virginia Medicaid Managed Care Organization (MCO), please follow the MCOs specific billing instructions.

Remember to always verify Medicaid eligibility before services are rendered.

VIRGINIA REGULATIONS FOR DISEASE REPORTING AND CONTROL

The Virginia Regulations for Disease Reporting and Control require physicians and the directors of laboratories to report any "detectable" blood lead levels in children ages 0-15 years to the Local Health Department within 3 days.

In October 2016, these regulations were updated and "Lead, elevated blood levels" was renamed "Lead, reportable levels". "Lead, reportable levels" now means any detectable blood lead level in children 15 years of age and younger and levels greater than or equal to 5 µg/dL in a person older than 15 years of age (12VAC5-90-10). This requirement applies to test results confirmed by a CLIA-certified laboratory. Results of office-based screening tests do not need to be reported.

Many laboratories submit disease reports by means of secure electronic transmission. Reports may also be submitted by using the Epi-1 form that can be found on the Virginia Department of Health (VDH) web site at: http://www.vdh.virginia.gov/content/uploads/sites/13/2016/03/Epi1.pdf

For more information, please visit the VDH web site: http://www.vdh.virginia.gov/surveillance-and-investigation/commonwealth-of-virginiastateboard-of-health/

MEDICAID FUNDED ENVIRONMENTAL INVESTIGATIONS

Environmental investigations are a service offered by Medicaid through Lead-Safe Virginia and local health departments. Environmental investigations are reimbursed to local health departments enrolled with DMAS or contracted with a Virginia Medicaid MCO. Medicaid funds are not available for the testing of environmental substances such as water, paint, or soil. Environmental investigations are conducted when certain criteria are met and may be carried out by private entities or environmental health specialists in local health departments who are licensed risk assessors. For information about what triggers an environmental lead investigation and what it includes, go to http://www.vdh.virginia.gov/environmental-health/childhood-leadpoisoning-prevention.

For additional questions about environmental lead testing, contact Lead-Safe Virginia toll-free at 1-877-668-7987. You may also email Lead-Safe Virginia at leadsafe@vdh.virginia.gov.

Resources for more information about blood lead testing and lead exposure

Lead-Safe Virginia

https://www.cdc.gov/nceh/lead/programs/va.htm

The National Lead Information Center (NLIC)

Environmental Protection Agency (EPA)

https://www.epa.gov/lead

CDC Childhood Lead Poisoning Prevention Program

https://www.cdc.gov/nceh/lead/

Coalition To End Childhood Lead Poisoning

http://www.greenandhealthyhomes.org/StrategicPlanforEndingLeadPoisoning

Additional Laboratory Procedures

In addition to the lead toxicity screening, the following procedures on laboratory tests are required:

Neonatal Screening

The screening provider must review the results of the newborn metabolic screening for phenylketonuria, hypothyroidism, galactosemia and other disorders performed prior to hospital discharge.

Sickle Cell Screening

The screening provider must review the results of the sickle cell screening performed prior to hospital discharge on the appropriate population. A sickle cell preparation must be done at the six (6) month old visit if indicated in accordance with AAP guidelines.

Anemia Screening

Iron deficiency anemia screening involving taking hematocrit or hemoglobin values through a finger prick or venous blood sample must be performed at screening visits in accordance with AAP guidelines.

Anemia screening, is a Medicaid reimbursable service, and should be administered more frequently if medically indicated. The results can be shared with the patient's written consent if the certification is needed for the Supplemental Nutrition Program for Women, Infants and Children (WIC).

EPSDT Optional Screening Procedures

The following is a description of **optional** screening procedures to be performed on children and adolescents at risk:

Tuberculin Test (Optional)

Tuberculin testing using the Purified Protein Derivative (PPD) skin test should be performed in accordance with AAP guidelines. The PPD test has replaced the Tyne method.

Cholesterol Screening (Optional)

Cholesterol and hyperlipidemia screening should be performed at each screening visit beginning at age two in accordance with AAP guidelines.

Sexually Transmitted Disease (STD) Screening (Optional)

All sexually active adolescents should be screened for sexually transmitted diseases such as chlamydia, gonococci, and syphilis at each screening visit beginning at age 11 through age 20. HIV testing should be performed if requested or if the adolescent is at high risk.

Cancer Screening (Optional)

A Papanicolaou (Pap) smear should be performed on all sexually active females at each screening visit.

Pelvic Examination (Optional)

All sexually active females should have a pelvic examination. A pelvic examination and a Pap smear must be offered as part of preventive health maintenance between the ages of 18 and 21.

Anticipatory Guidance

Health Education, also called “Anticipatory Guidance”, and problem focused guidance and counseling are provided at each well child visit according to developmental needs and with respect to patient cultural backgrounds and literacy levels.

The **Bright Futures** program has family friendly materials that provide useful anticipatory guidance information and age appropriate safety and parenting tips. For more information on Bright Futures, go to the web based training module at http://www.vdh.virginia.gov/brightfutures/ DMAS endorses **Bright Futures** and **Bright Futures Virginia**.

Referral to Dental Screening

Federal EPSDT regulations require a direct referral to a dentist beginning at age three. An oral inspection must be performed by the EPSDT screening provider as part of each physical examination for a child screened at any age. Tooth eruption, caries, bottle tooth decay, developmental anomalies, malocclusion, pathological conditions or dental injuries must be noted. The oral inspection is not a substitute for a complete dental screening examination provided through direct referral to a dentist.

The PCP or other screening provider must make an initial direct referral to a dentist when the child receives his or her three-year screening. The initial dental referral must be provided at the initial medical screening regardless of the periodicity schedule on any child age three or older unless it is known and documented that the child is already receiving regular dental care. The importance of regular dental care must be discussed with the family (and child as appropriate) on each screening visit for children three (3) years and older. When any screening, even as early as the neonatal examination, indicates a need for dental services at an earlier age, referral must be made for needed dental services.